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DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Food and Drug Administration

San Francisco District
1431 Harbor Bay Parkway
Alameda, California 94502
Telephone (510) 337-6700

March 20, 1997

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Wm. Andrew Heaton, M.D.
President/Responsible Head
Irwin Memorial Blood Centers
270 Masonic Avenue
San Francisco, CA 94118

WARNING LETTER

Dear Dr. Heaton,

An inspection of Irwin Memorial Blood Centers located at 270 Masonic Avenue, San Francisco, California on January 9 through February 28, 1997, by Investigators Deborah Kleinfeld and Tania Y. Hall documented violations of the Food Drug and Cosmetic Act and the Public Health Service Act, Biological Products. Specifically, the inspection revealed that blood and blood products are adulterated within the meaning of Section 501(a)(2)(B) of the Food, Drug, and Cosmetic Act in that the methods used in, or the facilities or controls used for, manufacturing, processing, packing or holding do not conform to or are not operated or administered in conformity with Current Good Manufacturing Practice for Blood and Blood Components specified in Title 21, Code of Federal Regulations (21 CFR), Parts 606, as follows:

1. Failure to maintain complete and accurate records for donor identity in that:

   a. At least two donors were found to have more than one donor identity number assigned, resulting in more than one identity existing for each donor in the system (i.e. duplicate donor) [21 CFR 606.160(c)].

   b. There are no additional formal activities (manual or computerized) being done to search for duplicate donors on a regularly scheduled basis to supplement the two existing search methods which are not detecting all possible duplicate donors [21 CFR 606.160 (b) (1)].

2. Failure to use supplies, viral marker test kits, in a manner consistent with the instructions provided by the manufacturer [21 CFR 606.65 (e)] in that it can not be determined if

plates are read within the time frames stated in the manufacturer's insert because the firm does not document the plate read times for the Ortho viral marker tests performed.

3. Failure to review all records pertinent to a unit of blood or blood component prior to the release or distribution of the final product [21 CFR 606.100(c)] in that:

   a. There is no review of changes made to donor records by data entry employees at donor registration.

   b. Units involved in post donation information reports are released and available for distribution before final review.

4. Failure to maintain concurrent, detailed and/or accurate records in that:

   a. Records of HIV p24 antigen plate ID #'s 0409, 0415, 0379, 0390, 0273, dated 3/18/96 & 3/19/96, and HBc plate ID #0464, dated 9/9/96, state the plates are re-reads. There is no documentation to determine why the plates had to be re-read [21 CFR 606.160 (a)].

   b. Two employees signed and inappropriately dated, after the fact, training records for Anti-HCV 3.0 Antibody ELISA test and one employee inappropriately dated, after the fact, maintenance records for repairs made to a plasmapheresis machine [21 CFR 606.160 (b)].

   c. All steps in the decision making process were not documented for units involved in post donation information reports H0238 and H0240. These units were released and shipped without documenting the reason why the units were considered suitable for release [21 CFR 606.160 (a)].

5. Failure to maintain adequate written standard operating procedures [21 CFR 606.100(b)] in that:

   a. SOP 4.627, the Summit Maintenance Procedure, is referenced in other SOPs dating back to 1993 but SOP 4.627 does not exist.

   b. SOP 8.010, Data Entry Modify Donor Record Procedure, allows for several donor identifying elements to be changed. The procedure does not describe what or how many identifiers must be the same in order to modify other identifiers. The procedure does not describe when print outs from before and after the modification are necessary.

c. SOP 8.014, Data Entry Donor Registration Procedure, instructs to update records of repeat donors when necessary. The procedure does not describe what type of updates can and cannot be made and what information must be the same before a change can be made.

d. SOP 8.014, Data Entry Donor Registration Procedure, does not require data entry personnel to check both the first and second part of hyphenated last names at donor registration as a step to prevent creating duplicate donors. There is at least one duplicate donor that your firm found where the investigation revealed the data entry clerk had not checked both sides of the hyphenated name.

e. SOP 6.800, Laboratory Post Donation Information Response, does not define "flu symptoms" but deems units unsuitable if symptoms develop within 4 days of donation.

f. SOP 19.007, Investigation of Post Donation Information Reports by Epidemiology, does not detail when final review must take place and what the final review consists of.

g. SOP 11.300, Investigation of Possible Duplicate Donors, does not address what to do if not enough information is available to reach a decision on whether donors are separate individuals or are duplicates. There is at least one case where a decision was made to maintain the possible duplicate donors as separate individuals even though there was not enough information to reach a conclusion.

h. The procedure for service requests is inadequate in that there is no tracking system by which the originator of a service request is required to monitor that these requests, when referred to other departments, are investigated and then routed to Computer Services if required.

i. SOP 10.104, Microliter Pipette Calibration, does not require a time frame for review of the calibration records. As a result, review of records did not occur until 6 to 14 months later.

j. The Apheresis Department does not have a SOP requiring a time frame for review of equipment maintenance and calibration that is performed.

6. Failure of management to assure that employees are adequately trained [21 CFR 606.20] in that:

a. There are no training records for two employees that have been performing volume verification (to verify pipette accuracy) on the Ortho Summit Sample Handling System for viral marker testing.

b. SOP 19.007, Investigation of Post Donation Information Reports by Epidemiology, was not followed, resulting in a donor being deferred for one year rather than permanently.

c. SOP 6.800, Laboratory Post Donation Information Response, was not followed, resulting in the release and shipment of unit GE61576 that did not meet release criteria.

We note, with regard to your computer system, that control over access to the Donor Registration Program was not exercised. Numerous employees had access to this program which you have since determined inappropriate. Once accessed, this program allows changes to virtually all donor record fields. There is no record of all the changes made and which employees made them.

Please be advised that the agency's memorandum dated April 6, 1988, entitled "Recommendations for Implementation of Computerization in Blood Establishments" indicates as a data security issue that "if key elements of the database are changed, these changes should be traceable as to the time and person making the changes so that integrity and reproducibility of data are assured." In addition, the agency's memorandum dated September 8, 1989, "Requirements for Computerization of Blood Establishments" states that among other requirements, "Security procedures to prevent unauthorized entry and physical access to the computer system" and "Procedure for control of changes in hardware/software" must be incorporated into SOPs. Copies of both these memoranda were provided to your firm with the Warning Letter dated January 13, 1993 and are enclosed with this letter.

We acknowledge receipt of your March 11, 1997 letter in which you address the inspectional observations listed on the Form FDA-483 and the corrective actions taken. This letter will be made part of our files.

The above violations are not intended to be an all-inclusive list of deficiencies at your facility. It is your responsibility as Responsible Head to assure that your establishment is in compliance with all requirements of the federal regulations.

You should take prompt measures to correct these deviations. Failure to promptly correct these deviations may result in regulatory action without further notice. Such action includes license suspension and/or revocation, seizure and/or injunction.

Please notify this office in writing, within 15 working days of receipt of this letter, of the specific steps you have taken to correct the noted violations and to prevent their recurrence. If corrective action cannot be completed within 15 working days, state the reason for the delay and the time within which the corrections will be completed.

Your reply should be sent to:

Suzanne Schenck, Compliance Officer
U.S. Food and Drug Administration
1431 Harbor Bay Parkway
Alameda, California 94502

Sincerely yours,

Patricia C. Ziobro

Patricia C. Ziobro,
District Director

Enclosures:

Agency memorandum, April 6, 1988, Recommendations for Implementation of Computerization in Blood Establishments

Agency memorandum, September 8, 1989, Requirements for Computerization of Blood Establishments